STATE OF CALIFORNIA

OFFICE OF ADMINISTRATIVE LAW

2003 OAL Determination No. 1

April 14, 2003

Requested by: **REGINA M. BOYLE**

Concerning: **DEPARTMENT OF CORPORATIONS, and its successor, the DEPARTMENT OF MANAGED HEALTH CARE – Issuance of limited licenses and exemptions from the Knox-Keene Act.**

Determination issued pursuant to Government Code section 11340.5.

ISSUE

Do the alleged rules of the Department of Corporations, and its successor, the Department of Managed Health Care, regarding the issuance of Knox-Keene limited licenses and licensure exemptions from the Knox-Keene Act, constitute "regulations" that are required to be adopted pursuant to the rulemaking provisions of the Administrative Procedure Act?[1]

CONCLUSION

The Office of Administrative Law deems as moot the issue of whether the issuance of limited licenses by the Department of Corporations before January 1, 2000, was subject to the Administrative Procedure Act because Health and Safety Code section 1349.3 strictly prohibited the issuance of limited licenses after January 1, 2000, and there is no evidence that either the Department of Corporations or the Department of Managed Health Care have issued any limited licenses since January 1, 2000.

Furthermore, the Office of Administrative Law concludes there is no rule or standard of general application concerning exemptions from Knox-Keene licensure other than those exemptions that exist in law.

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1. The request for determination was filed by Regina M. Boyle, later represented by Mary Lynn Belsher, Attorney at Law, 1420 "F" Street, Modesto, CA 95354. Agency responses were submitted by William Kenefick, Acting Commissioner of the Department of Corporations at the time the request was submitted, and by Jim Tucker, Chief Deputy Director of the Department of Managed Health Care. A public comment was submitted by Dick Thornley, Vice President of the California Association of Physician Organizations. The request was given a file number of 00-013. This determination may be cited as "2003 OAL Determination No. 1."

BACKGROUND

At the time the request was filed with the Office of Administrative Law (OAL) on February 22, 2000, the Department of Corporations ("DOC") was responsible for administering the Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene Act").[2] The Knox-Keene Act provides for the regulation of health care service plans in the State of California. Health and Safety Code section 1342 declares that "It is the intent and purpose of the Legislature to promote the delivery and the quality of health and medical care to the people of the State of California . . ." and itemizes eight goals.[3] Health and Safety Code section 1349 declares that

> "It is unlawful for any person to engage in business as a plan in this state or to receive advance or periodic consideration in connection with a plan from or on behalf of persons in this state unless such person has first secured from the director a license, then in effect, as a plan or unless such person is exempted by the provisions of Section 1343 or a rule adopted thereunder. . . ."

On July 1, 2000, authority to administer the Knox-Keene Act was transferred to what is now called the Department of Managed Health Care ("DMHC").[4]

In her determination request dated February 17, 2000, Ms. Boyle stated:

> "Certain IPAs [Independent Practice Associations] have received 'limited Knox-Keene licenses.' . . . [T]here is no regulation which permits the issuance of such licenses."[5]

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2. Health and Safety Code section 1341.

3. Health and Safety Code section 1342 sets forth the eight goals in subdivisions (a) through (h) as follows:

> "(a) Ensuring the continued role of the professional as the determiner of the patient's health needs which fosters the traditional relationship of trust and confidence between the patient and the professional.
> (b) Ensuring that subscribers and enrollees are educated and informed of the benefits and services available in order to enable a rational consumer choice in the marketplace.
> (c) Prosecuting malefactors who make fraudulent solicitations or who use deceptive methods, misrepresentations, or practices which are inimical to the general purpose of enabling a rational choice for the consumer public.
> (d) Helping to ensure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers.
> (e) Promoting effective representation of the interests of subscribers and enrollees.
> (f) Ensuring the financial stability thereof by means of proper regulatory procedures.
> (g) Ensuring that subscribers and enrollees receive available and accessible health and medical services rendered in a manner providing continuity of care.
> (h) Ensuring that subscribers and enrollees have their grievances expeditiously and thoroughly reviewed by the department."

4. Health and Safety Code section 1343, Stats. 1999, ch. 525 (AB 78). Initially known as the Department of Managed Care, the agency's name was later changed to the Department of Managed Health Care. (Stats. 2000, ch. 857 (AB 2903).)

5. Ms. Boyle's February 17, 2000 determination request, page 5, footnote 10.

Ms. Boyle also stated that providers receiving capitation should be licensed under the Knox-Keene Act. Ms. Boyle characterized the fact that providers who receive capitation were not licensed was ". . . the direct result of the creation of an informal and vague exemption . . . without compliance with the Administrative Procedure[] Act."[6]

Accordingly, for purposes of this determination, OAL analyzes the following rules:

(1) issuance of limited Knox-Keene Act licenses, and
(2) unspecified exemptions from Knox-Keene Act licensure.

ANALYSIS

A determination of whether the challenged rules are "regulations" subject to the Administrative Procedure Act (APA) depends on (1) whether the APA is generally applicable to the quasi-legislative enactments of DOC and DMHC, (2) whether the challenged rules contain "regulations" within the meaning of Government Code section 11342.600, and (3) whether the challenged rules fall within any recognized exemption from APA requirements.

(1) Generally, all state agencies in the executive branch of government and not expressly exempted by statute are required to comply with the rulemaking provisions of the APA when engaged in quasi-legislative activities. *(Winzler & Kelly v. Department of Industrial Relations* (1981) 121 Cal.App.3d 120, 126-128, 174 Cal.Rptr. 744, 746-747; Gov. Code, secs. 11342.520 and 11346.) Moreover, the term "state agency" includes, for purposes applicable to the APA, "every state office, officer, department, division, bureau, board, and commission." (Gov. Code, sec. 11000.) The DOC and the DMHC are neither in the judicial nor legislative branch of state government, and therefore, unless expressly exempted by statute, the APA rulemaking requirements generally apply to both the DOC and DMHC.

Rules adopted by the Commissioner of the DOC are expressly made subject to the APA. Corporations Code section 25614 provides in part that:

> "All rules of the commissioner (other than those relating solely to the internal administration of the Department of Corporations) shall be made, amended, or rescinded in accordance with the provisions of the [APA]."

Health and Safety Code section 1343, subdivision (b), applied to the DOC when the determination request was filed and to the DMHC on and after July 1, 2000. Section 1343, subdivision (b), declares that:

> "The director may by the adoption of rules or the issuance of orders deemed necessary and appropriate, either unconditionally or upon specified terms and conditions or for specified periods, exempt from this chapter any class of persons or plan contracts if the director finds the action to be in the public interest and not detrimental to the protection of subscribers, enrollees, or persons regulated under

6. Ms. Boyle's February 17, 2000 determination request, page 2.

this chapter, and that the regulation of the persons or plan contracts is not essential to the purposes of this chapter."

Health and Safety Code section 1342.5 required the director of the DOC when the determination request was filed and the director of the DMHC on and after July 1, 2000, to:

> ". . . consult with the Insurance Commissioner prior to adopting any regulations applicable to health care service plans subject to this chapter and nonprofit hospital service plans subject to Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 of the Insurance Code and other entities governed by the Insurance Code for the specific purpose of ensuring, to the extent practical, that there is consistency of regulations applicable to these plans and entities by the Insurance Commissioner and the Director of the [DOC and later DMHC]."

Neither the DOC nor the DMHC has called our attention to, nor have we located, any statutory provision expressly exempting rules of the DOC and the DMHC from the APA. OAL therefore concludes that APA rulemaking requirements generally apply to both the DOC and the DMHC.

(2) Government Code section 11340.5, subdivision (a), prohibits state agencies from issuing rules without complying with the APA. It states as follows:

> "(a) *No* state agency shall issue, utilize, enforce, or attempt to enforce *any* guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule, which is a [']regulation['] as defined in Section 11342.600, *unless* the guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule has been adopted as a regulation and filed with the Secretary of State pursuant to [the APA]. [Emphasis added.]"

Government Code section 11342.600 defines "regulation" as follows:

> ". . . *every* rule, regulation, order, or standard of general application *or* the amendment, supplement, or revision of any rule, regulation, order, or standard adopted by any state agency to implement, interpret, or make specific the law enforced or administered by it, or to govern its procedure . . . . [Emphasis added.]"

Under Government Code section 11342.600, a rule is a "regulation" for these purposes if (A) the challenged rule is *either* a rule or standard of general application *or* a modification or supplement to such a rule and (B) the challenged rule has been adopted by the agency to *either* implement, interpret, or make specific the law enforced or administered by the agency, *or* govern the agency's procedure. (See *Grier v. Kizer* (1990) 219 Cal.App.3d 422, 440, 268 Cal.Rptr. 244, 251; *Union of American Physicians & Dentists v. Kizer* (1990) 223 Cal.App.3d 490, 497, 272 Cal.Rptr. 886, 890.)

For purposes of answering the question of whether the two rules are "regulations" as defined in Government Code section 11342.600, OAL will discuss below each rule separately.

RULE #1: ISSUANCE OF LIMITED LICENSES

Ms. Boyle stated in her determination request dated February 17, 2000:

> "Certain IPAs [Independent Practice Associations] have received 'limited Knox-Keene licenses.' . . . [T]here is no regulation which permits the issuance of such licenses."[7]

At the time Ms. Boyle's determination request was filed, Health and Safety Code section 1349.3, which became operative on January 1, 2000, established the following moratorium on limited licenses:

> "(a) On or after January 1, 2000, no license with waivers or limited license shall be issued to any person, including a provider or an affiliate of a provider, for the provision of, or the arranging, payment, or reimbursement for the provision of, health care services to enrollees of another plan under a contract or other arrangement whereby the person assumes financial risk for the provision of at least both physician services and hospital inpatient and ambulatory care services to the enrollees of the plan with which the person proposes to contract or make an arrangement. On and after January 1, 2000, no licensed health care service plan shall contract with any person, other than a licensed health care service plan or licensed health care service plan with waivers for the assumption of financial risk with respect to the provision of both institutional and noninstitutional health care services and any other form of global capitation. Nothing in this section may be construed to prohibit or authorize, other than as provided by existing law, any contracting for the assumption of financial risk for health care services.
>
> (b) An applicant for a license with waivers or a limited license that has an application on file with the director on August 1, 1999, shall be entitled to a refund of the application filing fee paid as of January 1, 2000.
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> (c) This section shall remain in effect only until January 1, 2002, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2002, deletes or extends that date."[8]

Ms. Boyle made no assertion that DOC issued any limited licenses after January 1, 2000. Health and Safety Code section 1349.3 was still operative when jurisdiction for the administration and enforcement of the Knox-Keene Act shifted from DOC to DMHC on July 1, 2000.

In its July 27, 2000 response letter, the DMHC asserted that Health and Safety Code section 1349.3 renders the request moot:

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7. Ms. Boyle's February 17, 2000 request, page 5, footnote 10.

8. No statute was later enacted that deleted or extended the January 1, 2002 date. Thus, as of January 1, 2002, section 1349.3 of the Health and Safety Code was no longer in effect.

> "The amendment to Health and Safety Code section 1349.3 precludes the Department as of January 1, 2000, from issuing limited licenses to providers that accept global capitation. Because provider organizations that have capitation agreements with HMO's do not qualify for full Knox-Keene licenses under section 1345(b), as of the present time, the Department cannot issue provider organizations any type of license. Therefore, the amendment to Health and Safety Code section 1349.3 effectively renders the issue of the determination request moot."[9]

DMHC declared under penalty of perjury in its October 16, 2001 letter, that:

> "The Department, since its initial existence, has followed the express statutory instructions and has never issued a full, limited, or license with waivers to any provider. Nor has the Department felt compelled to adopt a regulation for something it does not do, and which is statutorily prohibited. . . ."[10]

DMHC's website has a "Public Alpha Report" that lists all licensed plans as of 3/14/03.[11] Out of 105 total licensed plans, only four are listed as limited licenses. The most recent limited license was issued April 7, 1999, to Pro-Med Health Care Administrators. This website information is consistent with DMHC's October 16, 2001 statement under penalty of perjury that DMHC has not issued any limited licenses since it became operative on July 1, 2000. Furthermore, this information confirms that DOC also did not issue any limited licenses after January 1, 2000.

Ms. Belsher, Ms. Boyle's attorney, states that the fact that DMHC has taken no action to address the status of the remaining limited licenses existing at the time she wrote her letter does not render the determination request moot.[12] We do not agree. According to *Engelmann v. State Board of Education* ((1991) 2 Cal.App.4th 47, 62, 3 Cal.Rptr.2d 264, 274-275), agencies need not adopt as regulations those rules that reiterate a statutory scheme which the Legislature has already established.

It is important to note that Health and Safety Code section 1349.3 did not require existing limited licenses to be revoked. It mandated a refund to applicants who had not yet received a licensure decision from DOC, but it did not address what to do with the limited licenses already issued, and it did not declare previously-issued limited licenses to be void.

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9. DMHC July 27, 2000 response letter, page 3. In its May 26, 2000 response letter, the DOC stated " . . . a preliminary review of the issue raised and the documentation submitted by Ms. Boyle indicates that the issue may not require a determination as a result of the enactment of [Health and Safety Code Section 1349.3]."

10. DMHC response letter dated October 16, 2002, page 4.

11. California Department of Managed Health Care, "Public Alpha Report," <http://www.dmhc.ca.gov/library/reports/#licensed> [as of March 14, 2003].

12. At the time she submitted her letter to OAL dated August 6, 2000, Ms. Belsher stated that there were six existing limited licenses.

Thus, OAL deems as moot the issue of whether the issuance of limited licenses by DOC before January 1, 2000, was subject to the APA because Health and Safety Code section 1349.3 strictly prohibited the issuance of limited licenses after January 1, 2000, and there is no evidence that either DOC or DMHC have issued any limited licenses since January 1, 2000.

RULE #2: EXEMPTIONS FROM KNOX-KEENE LICENSURE

Ms. Boyle asserted there are over 300 unlicensed independent practice associations that accept pre-payment in the form of capitation in exchange for providing or arranging for the provision of health care services and this " . . . is the direct result of the creation of an informal and vague exemption from the licensing requirements by the Department of Corporations, without compliance with the Administrative [Procedure] Act."[13]

She also stated in her request that:

> "It is the practice of California health plans to make flat-fee payments to health care providers, medical corporations, and shell corporations known as 'independent practice associations' or 'IPAs' which are frequently insufficient to fully compensate the health care providers who actually provide the goods and/or services to the subscribers or enrollees of the health care services plan. *None of these persons or entities are licensed under the Knox-Keene Act, yet to the extent that they receive capitation payments* for providing or arranging for the provision of health care services to subscribers or enrollees of health care service plans, *they are fully within the definition of 'health care service plans' under Health & Safety Code §1345(f), and are required to be licensed under the Knox-Keene Act*. [Emphasis added.]"[14]

She further asserted that:

> "Certain IPAs have received 'limited Knox-Keene licenses.' Again, there is no regulation which permits the issuance of such licenses. SB 260 [Health and Safety Code section 1349.3] has created a moratorium on the issuance of limited licenses, and does not create any additional exemptions to the licensing requirement of Health & Safety Code §§1349 and 1353 for entities meeting the definition of HCSP [Health Care Service Plans] under Health & Safety Code §1345(f), including provider groups."[15]

Ms. Boyle's determination request challenging unspecified exemptions from the Knox-Keene Act can be simplified to its core structure. Her basic premise is that, in her opinion, providers who receive capitation meet Health and Safety Code section 1345, subdivision (f)'s definition of

13. Ms. Boyle's February 17, 2000 determination request, page 2.

14. *Ibid.*, page 5.

15. *Ibid.*, page 5, footnote 10.

a "health care service plan," and are, therefore, legally required to be licensed pursuant to the Knox-Keene Act. She then asserts that because there are providers receiving capitation who do not have a Knox-Keene Act license, then there must be an exemption or exemptions to Knox-Keene licensure that DOC applied and DMHC continues to apply.

In a letter dated April 18, 2000, Ms. Boyle augmented her request by stating:

> "To the extent that a written reflection of the rule . . . exists, I was orally informed by a duty officer in the Legal Department of the Health Plan Division of the Department of Corporations, during the week of February 17, 2000, that the exemption from the licensing requirement of Knox-Keene for provider groups receiving capitation is reflected in the written opinions or statements attached to the RFD as Exhibit 'I.'
>
> "To the extent that 1 CCR § 122(a)(3)(A) requires a request for determination to include '[a] copy of the state agency rule which is the subject of the request,' the exemption from licensing which is challenged is reflected most accurately in Dept. of Corporations, Comm.Ops. 91/1H, 5080H, 4730H and 4664H (**Exhibit 'I'**). [Bolding in original.]"

Ms. Boyle submitted the four DOC opinions[16] as exhibits in her February 17, 2000 request.[17] The four opinions were issued from 1983 through 1991.

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16. Commissioner's Opinion 91/1H (File No. OP 6095H), dated September 20, 1991, states, "THIS LETTER IS NOT AN INTERPRETIVE OPINION FOR THE REASONS STATED BELOW." (Capitalization in original.) The last paragraph of the opinion explains the status of an interpretive opinion:

> "Inasmuch as interpretive opinions are issued for the principal purpose of providing a procedure by which members of the public can protect themselves against liability for acts done or omitted in good faith in reliance upon the administrative determination made in the opinion, and since there can be no such reliance where the Commissioner asserts jurisdiction with respect to a particular situation or determines that a legal requirement is applicable, advice to that effect, as contained in this letter, does not constitute an interpretive opinion."

The other three opinions, File Nos. 1985 OP 5080H, 1983 OP 4730H and 1983 OP 4664H, are deemed interpretive opinions and contain the following proviso:

> "THIS INTERPRETIVE OPINION IS ISSUED BY THE COMMISSIONER OF CORPORATIONS PURSUANT TO SECTION 1344 (B) OF THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975. IT IS APPLICABLE ONLY TO THE TRANSACTION IDENTIFIED IN THE REQUEST THEREFOR, AND MAY NOT BE RELIED UPON IN CONNECTION WITH ANY OTHER TRANSACTION. [Capitalization in original.]"

The status of an interpretive opinion as being applicable to only the transaction of the inquiry is dispositive that whether a provider is a health care service plan required to have a Knox-Keene license had been made by the DOC on a case-by-case basis.

17. Among other documents submitted by Ms. Boyle was the DOC's response to a petition submitted by the California Medical Association ("CMA") that was printed in the California Regulatory Notice Register 99,

No. 3-Z, pages 122 – 128, (requester's Exhibit C). Both the DOC's response language quoted in Ms. Boyle's February 17, 2000 request and the issue involved in the petition do not directly apply to the determination request.

On behalf of Ms. Boyle, Ms. Belsher submitted an article from the 12(1) *California Health Law News* (pp. 23-24, Spring 1992) that was written by Warren Barnes, Supervising Counsel in the Health Care Services Plan Division of the DOC as illustrating the DOC's rules for exemptions. (See Ms. Belsher letter to OAL dated 8/6/00.) However, the article, titled "Issues Related to Health Care Service Plan Licensure," clearly states that "The views expressed in this article are those of Mr. Barnes and do not necessarily reflect the views of the Commissioner or the policy of the Department of Corporations." Therefore, it cannot be attributed to the DOC or to its successor, the DMHC, and is not dispositive.

Numerous articles on the financial crisis in the health care industry and a summary of schedules for the Chapter 11 bankruptcy filing for Mission Independent Practice Association Medical Group, Inc., were also submitted by Ms. Boyle. Although Ms. Boyle characterizes the Mission Group as having met the definition of a health care plan that was not Knox-Keene licensed and no enforcement action was taken against them, the actual document which lists debts does not establish whether or not they needed licensing or were statutorily exempted from licensing and more importantly does not contain a rule of the DOC or the DMHC. Her assertions and these documents raise enforcement and policy issues which are beyond the scope of this determination.

Ms. Boyle also submitted quotes from "Managed Care Potpourri: Medi-Cal, Workers' Compensation & Beyond," 16 Whittier L. Rev. 87, 104, (Mickelson, Angela, and Gold, Eric, and Spohn, Richard B.) [a copy of the article was submitted as Exhibit D]:

> *"**Question***: My understanding is the 'Pioneer Hospital" [beyond the scope of professional licensing or 'full risk' capitation] arrangements have existed for ten years. Why have they become controversial now? How did DOC [the Department of Corporations, Health Plan Division] become aware of them?
>
> ***Ms. [Mickelson]***: I would be surprised if Pioneer Hospital arrangements have existed for ten years. Even if they have, DOC is not aware of everything that is occurring in the industry. Further, some of the HMOs do not know about all of the subsidiary arrangements their contracting providers are engaged in and, consequently, do not report those arrangements to DOC. Then there are other HMOs that simply choose not to report those arrangements to DOC.
>
> In addition, I do not think that DOC suddenly became aware of the Pioneer Hospital arrangements. *Rather, I think that certain DOC regulators not only knew about, but actually approved those arrangements. <u>The real problem is that there is disagreement among DOC regulators as to whether Pioneer Hospital downside risk and certain other provider risk sharing arrangements should be permitted. This lack of consensus has led to inconsistent regulation over the years, both from a licensing and an enforcement standpoint.</u> The major side effect of inconsistent regulation has been the creation of an unequal playing field. This unequal playing field, and other industry pressures, caused DOC to decide to take a fresh look at its past practices and policies regarding provider risk sharing arrangements, and led to the establishment of the Risk Committee.* [February 17, 2000 request, page 7; italicized emphasis in request; underlining emphasis added.]"

This statement is not an official DOC articulation of a rule, but rather is one person's opinion that there is inconsistency in licensing and enforcement, which are issues beyond the scope of this determination.

A review of the four DOC opinions shows a case-by-case analysis of factors unique to each inquiry including but not limited to corporate structure, terms and provisions of contracts including whether functions are ministerial or not, and payment provisions. But the question remains, did DOC use a rule or standard of general application in reaching their decision in these four DOC opinions? We think not. No clear rule or standard of general application is evident in the four opinions.

We note that all four opinions contain similar statements about superseding arrangements made by third party payors. Commissioner's Opinion 91/1H issued on September 20, 1991, contains the following statement:

> "Previous opinions of the Commissioner *express the view, under unique and limited facts*, that a person is not a health care service plan within the meaning of Section 1345(f), if the person's arrangements for the provision of health care services are superseded by the arrangements necessarily made by the payor itself in order for health care services to be provided to the payor's beneficiaries. (See Comm. Ops. 5080H, 4730H and 4664H.) [Emphasis added.]"

Rather than being criteria, this appears to OAL to be a summary of the three prior opinions' conclusions based on specific unique facts. We decline to extrapolate a general rule from four Commissioner opinions that expressly apply only to the specific facts in those specific inquiries. Furthermore, Ms. Boyle is also unable to identify or describe the specific rules or standards used by DOC and DMHC, if any, concerning the alleged exemptions from Knox-Keene licensure (she describes the alleged exemption as being "informal and vague").[18] Thus, OAL concludes there is no rule or standard of general application concerning exemptions from Knox-Keene licensure other than what exists in law.

DATE: April 14, 2003

SHEILA R. MOHAN
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OAL can only issue a determination based on documented challenged rules. It is our opinion that all of the submitted documentation described in this footnote does not clearly establish a rule or standard of general application.

18. Ms. Boyle's February 17, 2000 determination request, page 2.

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